The
Westgate Practice

Patient consent for third parties to access their medical record

Patient Name:

Address:

DOB:

The above patient has given the following people access to either all or part of their medical record.

Name:

Address:

Telephone No:

Relation to Patient:

Name:

Address:

Telephone No:

Relation to Patient:

Please tick which section of your medical record you would like the above people to have access to:

Access to all	☐	Prescriptions	☐
Results	☐	Appointments	☐
Hospital/Consultant letters	☐		

Please note that this document will remain on your record until you notify us to remove. If any of the above information changes please notify the practice.

I .... confirm that I allow the above named people to have access to my record as outlined above.

Signature:

Date:

Office use only:

GP Authorisation: ☐

Scanned onto patients notes: ☐

Alert entered onto medical record: ☐